

Instructions

1. Complete the information below. Please print.
2. Attach the documentation in the order in which you have the expenses listed.
3. The documentation must contain the date(s) of service, expense incurred and the name of the service provider.
4. Cancelled checks and credit card receipts are not a valid form of documentation.
5. This form must be signed and dated in order to be processed and approved.

6. Please submit the form with your supporting documentation using one of the following methods:

Fax: (781) 213-7304
Email: claims@sentinelgroup.com
Mail: 55 Walkers Brook Drive, Suite 100
Reading, MA 01867

Employee Information

Social Security Number _____

Last Name _____

First Name _____

Street Address _____

City _____

State _____

Zip _____

Email Address _____

Phone Number _____

Claim Information

Date of Service	Provider of Service	Outpatient Surgery	Emergency Room	High Tech Imaging	Inpatient/ Outpatient	Amount Requested
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Total Amount:

**Claim Information -
Out of Pocket Maximum Met***

*In the event that any one member or family has out of pocket costs for covered services from in-network providers, that are not already reimbursed by the HRA (including prescription drug copayments, deductibles and office visit copayments) and that exceed \$1,250 per member/\$2,500 per family in total per year, the HRA will provide reimbursement of 100% of the cost for covered services from in-network providers over \$1,250 per member/\$2,500 per family in total per year.

Date of Service	Provider of Service	Type of Service/Expense	Amount Requested

Total Amount:

Certification

I request payment from my health reimbursement account (HRA) for the expenses itemized above. I certify that I have not previously requested reimbursement under this plan or from any other source for these expenses. I further certify that I have met all of the requirements for eligible healthcare expenses. I understand that reimbursement expenses cannot be claimed on my personal income tax return or my flexible spending account (FSA).

Employee's Signature _____

Date _____